Indiana State Teachers' Retirement Fund

Anthem

Anthem Insurance Companies, Inc.
P.O. Box 390
Indianapolis IN 46206-0390

Health Insurance Application
Underwritten By:
Anthem Insurance Companies, Inc.

Complete this section if you are applying for Plan 1 coverage for yourself.				Complete this section if you are applying for Plan 1 coverage for spouse.			
Please Print				Please Print			
Member Name Last First M.I.				Spouse Name Last First M.I.			
Print Address Street				Print Address Street			
City State Zip				City State Zip			
Birth Date Mo. Day Year		☐ Male ☐ Female	☐ Single ☐ Married	Birth Date Mo. Day Year		☐ Male ☐ Female	
Social Security Number		Medicare H.I.C. No.		Social Security Number		Medicare H.I.C. No.	
Medicare Eff. Date	Part A_____ Part B_____	Home Telephone Number ( )		Medicare Eff. Date	Part A_____ Part B_____	Home Telephone Number ( )	
Date Retired Month/Year		TRF No.		Date Retired Month/Year		TRF No.	
Complete for Plan 1 Coverage: Option A ☐ with prescription drugs Option B ☐ without prescription drugs				Complete for Plan 1 Coverage: Option A ☐ with prescription drugs Option B ☐ without prescription drugs			

Complete if you wish to add a Dependent Child who is enrolled in Medicare.

Reason for Entitlement: Age:___ Disability: ___ ESRD: ____ ESRD & Disability: ____

ESRD Onset Date: _____

DO NOT USE

First Name Initial Last Name	Birthday	Relationship		Rel	Med	Elig
	Mo Day Yr	☐ Son ☐ Daughter	Option A ☐ with prescriptions			
Medicare H.I.C. No._____ Medicare Effective Date Part A_____ Part B_____			Option B ☐ without prescriptions			

Please answer the following questions

Are you or any listed Dependent presently enrolled in any other type of Hospital and/or Medical Insurance?
If yes, complete the following questions:

Name of Policyholder_____ Policy #_____
Policyholder's Social Security No._____
Policyholder's Birthday: Mo._____ Day_____ Yr._____
Name of Employer_____
Employer's Address_____
(Street) (City) (State) (Zip Code)
Name of Insurance Co._____ Eff. Date_____
Insur. Co. Address_____
(Street) (City) (State) (Zip Code)

PENSION DEDUCTION AUTHORIZATION

I wish to enroll in the Retired Teachers' Group Health Plan and by completion of the following deduction authorization, do hereby authorize the Teachers' Retirement Fund to deduct from my benefit check amounts sufficient for my contribution (if any) toward premiums for group insurance for which I and my dependents (if enrolled) are or may become eligible.

SS No._____ TRF Retiree No._____

Signature_____

OFFICE USE ONLY Premium_____ Effective Date_____

S35J-290 R7 (02/02)

PLEASE SEE REVERSE SIDE

Please Sign the Application on the Lines Below

I authorize any provider of health services to disclose to Anthem or its affiliates and any other company that provides services on behalf of Anthem, any information or records concerning claims, conditions, or treatments for myself, my spouse and my dependents enrolled under the Plan for the purpose of payment of claims, health care operations and plan administration including but not limited to, quality improvement, utilization review, coordination of benefits, subrogation, audits and health promotion, disease management and prevention programs. I understand that Anthem may furnish information without prior authorization, to the Group. Anthem may also furnish information, without prior authorization, to others for legitimate business reasons including, but not limited to, reinsurers and pharmacy benefit managers.

SIGNATURE _____**DATE**_____

Please cancel my existing membership with Anthem Insurance Companies, Inc. on the effective date of my coverage through the Indiana State Teachers' Retirement Fund Contract. I understand that I am not eligible for this coverage if I already have any health coverage, group or individual, which will not be cancelled. My current identification number is: _____.
Identification Number

MEMBER'S SIGNATURE_____ **DATE**_____

Please cancel my existing membership with Anthem Insurance Companies, Inc. on the effective date of my coverage through the Indiana State Teachers' Retirement Fund Contract. I understand that I am not eligible for this coverage if I already have a health coverage, group or individual, which will not be cancelled. My current identification number is: _____.
Identification Number

SPOUSE'S SIGNATURE_____ **DATE**_____

Control No.	Benefit Code	Effective Date	Paid-to-Date
Multi-Bill Code	Segment Code	Department No.	S.S. or Clock No.

MED	NPT	Dual ID No.	Variation Code	Variation Effective Date	Code	Prior Coverage Credit ID No.